Speech, Physical and Occupational Therapy

Contract #04-015_

PURCHASE OF SERVICE CONTRACT

Parties and Contract Period

This contract is between **Marinette County Health & Human Services Department,** whose business address is **2500 Hall Avenue, Suite B, Marinette WI 54143**, hereinafter referred to as Purchaser and **<<<Provider name>>>** whose business address **<<<address>>>,** hereinafter referred to as Provider. This contract is to be effective for the period **January 1, 2004 through December 31, 2004**.

The Provider employee responsible for day-to-day administration of this contract will be **<<< contact person>>>, <<<phone>>>** whose business address is **<<<Address>>>.** In the event that the administrator is unable to administer this contract, Provider will contact Purchaser and designate a new administrator.

The Purchaser employee responsible for day-to-day administration of this contract will **<<< contact person>>>, <<<phone>>>** whose business address is **2500 Hall Avenue, Suite B, Marinette, WI 54143**. In the event that the administrator is unable to administer this contract, Purchaser will contact Provider and designate a new administrator.

Article 1 Audit

Section 1.1 Type of audit
The Provider shall submit an annual agency-wide audit to the Purchaser if the total amount of annual funding provided by the Purchaser through this and other contracts is $25,000 or more.

Section 1.2 Audit Standards
The audit shall be in accordance with the requirements of OMB Circular 1-133 "Audits of States, Local Governments, and Non-Profit Organizations" (on line at *www.whitehouse.gov/omb/circulars*) if the provider meets the criteria of the Circular for needing an audit in accordance with the Circular. The audit shall also be in accordance with the following department standard:

a. The *State Single Audit Guidelines* (on line at *www.ssag.state.wi.us*) if the Provider is a local government that meets the criteria of OMB Circular A-133 for needing an audit in accordance with that Circular of

b. The *Provider Agency Audit Guide* (on line at *www.dhfs.state.wi.us/grants*) for all other Providers.

Section 1.3 Audit Schedules
In addition to the schedules required under the *State Single Audit Guidelines* or the *Provider Agency Audit Guide*, the reporting package sent to the Purchaser shall include a supplemental schedule showing revenue and expenses for this contract.

For profit providers shall include a schedule in their audit reports showing the total allowable costs and the calculation of the allowable profit by contract or by service category.

Non-profit providers shall include a Reserve Supplemental Schedule (Section 7.1.6 of the *Provider Agency Audit Guide*) in their audit reports, and this schedule shall also be by contract or service category.

Section 1.4 Submitting the Reporting Package
The Provider shall send the required reporting package to the Purchaser at the address listed in this contract. The reporting Package is due to the Purchaser within 180 days of the end of the Provider's fiscal year.

Section 1.5 Access to auditor's work papers
When contracting with an audit firm, the Provider shall authorize its auditor to provide access to work papers, reports, and other materials generated during the audit to the appropriate representatives of the Purchaser. Such access shall include the right to obtain copies of the work papers and computer disks, or other electronic media, which document the audit work.

Section 1.6 Failure to comply with the requirements of this section
If the Provider fails to have an appropriate audit performed or fails to provide a complete audit-reporting package to the Purchaser within the specified timeframe, the Purchaser may:

a. Conduct an audit or arrange for an independent audit of the Provider and charge the cost of completing the audit to the provider;

b. Charge the Provider for all loss of federal or state aid or for penalties assessed to the Purchaser because the Provider did not submit a complete audit report within the required time frame;

c. Disallow the cost of the audit that did not meet the applicable standards/ and/or

d. Withhold payment, cancel the contract, or take other actions deemed by the Purchaser to be necessary to protect the Purchaser's interests.

Article 2 Caregiver Background Checks

The Purchaser and the Provider agree that the protection of the clients served under this contract is paramount to the intent of this contract. In order to protect the clients served, the Provider shall comply with the provisions of HFS 12, Wis. Admin. Code (online at *http://www.legis.state.wi.us/rsb/code/index.html*)

Section 2.1 Provider Screening/Background checks
Provider Screening Requirements: All persons who provide direct contact with the clients of the Purchaser shall be subject to criminal and caregiver background checks at the Provider's own expense. The Provider shall retain in its Personnel Files all pertinent information, to include a Background information Disclosure Form and/or search results from the Department of Justice, the Department of Health and Family Services, and the Department of Regulation and Licensing, as well as out of state records, tribal court proceedings and military records, if applicable.

Both types of background checks must be repeated every four years, or at any time within that period when the Provider has reason to believe a new check should be obtained.

Persons who are listed on the caregiver register, or who are found to have committed a crime substantially related to the provision of these services such as misappropriation of participant funds, shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

Section 2.2 Records
The Provider shall maintain the results of background checks on its own premises for at least the duration of the contract. The Purchaser may audit the Provider's personnel files to assure compliance with the State of Wisconsin Caregiver Background Check Manual (online at http:www.dhfs.state.wi.us/caregiver/bublications/CgvrProgMan.htm).

Section 2.3 Assignment of staff
The Provider shall not assign any individual to conduct work under this contract who does not meet the requirement of this law.

Section 2.4 Notification to Purchaser
Providers must communicate with county staff and other providers within confidentiality laws, any incidents or situations regarded as Critical Incidents as defined in the Medicaid Home and Community-Based Services Waivers Manual, Chapter 9.

The Provider shall notify the Purchaser in writing via certified mail within one business day if an employee has been charged with or convicted of any crime specified in HFS 12.07(2) (online at *http://www.legis.state.wi.us/rsb/code/index.html*).

Article 3 Civil Rights Compliance Plan

Article 3 Civil Rights Compliance Plan
The Civil Rights Compliance (CRC) Plan contains three components that cover Affirmative Action, Civil Rights/Equal Employment Opportunity, and Language Access. Providers that have more than twenty-five (25) employees and receive more than twenty five thousand dollars ($25,000) must develop and submit a Civil Rights Compliance Plan with all the three components mentioned above.

Providers that have less than twenty-five (25) employees or receive less than a total of twenty five thousand ($25,000) dollars must develop and submit a Letter of Assurance.

Section 3.1 Affirmative Action Component

A. Affirmative Action (AA) is the first component of the CRC Plan. A Provider must develop and submit an Affirmative Action Plan that covers a two or three-year period.

B. A Provider may request an exemption form submitting an AA Plane if it:

   1. Has an annual work force of less than twenty-five (25) employees,
   2. Is a governmental entity (e.g., county, municipality or state university), or
   3. Has a balanced work force.

C. Nevertheless, exempt Providers that do not have a balanced work force in specific job groups are required to develop and submit a recruitment strategy to address under-representation of the job group.

D. "Affirmative Action Plan" is a written document that details an affirmative action program. Key parts of an affirmative action plan are:

1. a policy statement pledging nondiscrimination and affirmative action employment,
2. internal and external dissemination of the policy,
3. assignment of a key employee as the Equal Opportunity Coordinator,
4. a workforce analysis that identifies job classifications where representation of women, minorities and the disabled are deficient,
5. Goals and timetables that are specific and measurable and that are set to correct deficiencies and to reach a balanced workforce,
6. a revision of employment practices to ensure that they do not have discriminatory effects, and
7. the establishment of internal monitoring and reporting systems to measure progress regularly.

E. A non-exempt Provider shall conduct, keep on file, and update annually a separate and additional accessibility self-evaluation of all programs and facilities, including employment practices for compliance with the Americans with Disabilities Title I regulations, unless an updated self-evaluation under Section 503 of the Rehabilitation Act of 1973 exists which meets the ADA requirements.

Section 3.2 Civil Rights/Equal Employment Opportunity Components

A. Civil Rights is the second component of the CRC Plan that must be developed and submitted. The civil rights requirements address non-discrimination in service delivery to clients, consumers, or patients.

1. All Providers must have the following policies and procedures to ensure that no otherwise qualified person shall be excluded form participation in, be denied the benefits of, or otherwise be subject to discrimination in any manner on the basis of race, color, national origin, sexual orientation, religion, sex, disability or age.

2. This policy covers eligibility for and access to service delivery and equal treatment in all programs and activities. All employees of the Providers are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.

B. Equal Employment Opportunity is another part to the second component in the CRC Plan. It addresses the requirements that the Provider must put in place to ensure non-discrimination in all employment conditions. The federal and state laws state that:

1. No otherwise qualified person shall be excluded form employment, be denied the benefits of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of age, race/ethnicity, religion, gender, sexual orientation, color, national origin or ancestry, disability (as defined in Section 504 of the Rehab Act and the Americans with Disabilities Act), arrest or conviction record, marital status, political affiliation, military participation, the use of legal products during non-work hours, non-job related genetic and honesty testing. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.

2. The Provider shall post the Equal Opportunity Policy, the name of the Equal Opportunity Coordinator and the discrimination complaint process in conspicuous

places available to applicants and clients of services, and applicants for employment and employees. The complaint process will be according to Purchaser's policies and procedures and made available in languages and formats understandable to applicants, clients and employees. The Purchaser will continue to provide appropriate translated program brochures and forms for distribution.

3. The Provider agrees to comply with the Purchaser's guidelines in the Civil Rights Compliance Plan Standards and a Resource Manual for Equal Opportunity in Service Delivery and Employment for the Wisconsin Department of Health and Family Services, its Service Providers and their Subcontractors.
4. Requirements herein stated apply to any subcontracts or grants. The Purchaser has primary responsibility to take constructive steps, as per the CRC Standards, to ensure the compliance of its subcontractors or grantees.

5. If a Provider of a county is a direct provider of the Department, this Provider will be required to develop and submit a CRC Plan to the Department. The county need not require this Provider to submit a second copy to the county.

6. The purchaser will monitor the Civil Rights Compliance of the Provider. The purchaser will conduct reviews to ensure that the Provider is ensuring compliance by its subcontractors or grantees according to guidelines in the CRC Standards. The Provider agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the Provider, as well as interviews with staff, clients, and applicants for services, subcontractors, grantees, and referral agencies. The reviews will be conducted according to Department of Health and Family Services procedures. The purchaser will also conduct reviews to address immediate concerns of complainants.

7. The Provider agrees to cooperate with the purchaser in developing; implementing and monitoring corrective action plans that result from complaint investigations or monitoring efforts.

Section 3.3 Language Access Plan

A. Language Access is the third component in the CRC Plan. It addresses the way programs and services are provided for persons with disabilities and Limited English Proficient (LEP) speakers.

B. For persons with disabilities, the Provider agrees that it will:

    1. Provide competent sign language interpreters for deaf or hard of hearing participants free of charge at any stage of application or receipt of services;

    2. Provide aids, assistive devices and other reasonable accommodations to the client during the application process, in the receipt of services, and in the processing of complaint or appeals;

    3. Train staff in human relations techniques, sensitivity to persons with disabilities and sensitivity to cultural characteristics;

4. make programs and facilities accessible, as appropriate, through outstations, authorized representatives, adjusted work hours, ramps, doorways, elevators, or ground floor rooms, and Braille, large print or taped information for the visually or cognitively impaired;

5. Post and/or make available informational materials in formats appropriate to the needs of the client population.

C. For limited English Proficient (LEP)

- The number or proportion of LEP persons eligible to be served or likely to be encountered by the Provider;
- The frequency with which LEP individuals come in contact;
- The nature and importance of the program, activity, or service provided by the program to people's lives, and
- The resources available to the Provider.

D. Upon the consideration of the four factors, the LEP policies require that the Provider have the following program components:

1. Analyze its service area to assess the primary language needs of the participants that it serves or encountered;

2. Establish a plan that will make oral interpretation available and free of charge upon request.

3. Disseminate written notice in the primary language of the LEP group that interpretation is available and free of charge to groups that constitute less than 50 individuals eligible to be served or encountered;

4. Provide written translations of vital documents to LEP participants that constitutes at least 5% or 1,000 LEP individuals, whichever is less, for the populations served or encountered.

5. Train staff about the Provider's LEP policies and procedures;

6. Collect data on primary language use of LEP participants to evaluate the program's effectiveness; and

7. Identify the LEP Coordinator and establish a complaint process that is accessible to LEP participants.

E. The provider will, to the extent possible, hire bilingual staff, work with community associations, contract with competent interpreters or other ways to ensure accurate interpretation while providing critical health care to an LEP consumer of patient.

Article 4 Client Funds

All client funds shall be handled by the Purchaser. The Provider shall not handle client funds.

Article 6 Conditions of the Parties' Obligations

Section 6.1 Contingency
This contract is contingent upon authorization of Wisconsin and Untied States laws and any material amendment or repeal of the same affecting relevant funding or authority of the Department of Health and Family Services shall serve to terminate this Agreement, except as further agreed to by the parties hereto.

Section 6.2 Powers and Duties
Nothing contained in this contract shall be construed to supersede the lawful powers or duties of either party.

Section 6.3 Items Comprising the Contract
Is understood and agreed that the entire contract between the parties is contained herein, except for those matters incorporated herein by reference, and that this Agreement supersedes all oral agreements and negotiations between the parties relating to the subject matter thereof.

Article 7 Confidentiality

Section 7.1 Client confidentiality
The provider shall not use or disclose any information concerning eligible clients who receive services from Provider for any purpose not connected with the administration of Provider's or Purchaser's responsibilities under this contract, except with the informed, written consent of the eligible client or the client's legal guardian.

Section 7.2 Contract not confidential
Except for documents identifying specific clients, the contract and all related documents are not confidential.

Article 8 Conflict of Interest

The provider shall ensure the establishment of safeguards to prevent employees, consultants, or members of the board from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business, or other ties.

Article 9 Debarment and Suspension

The provider certifies through signing this contract that neither the Provider nor any of its principals are debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in federal assistance programs by any federal department or agency. In addition, the Provider shall notify the Purchaser within five business days in writing and sent by registered mail if the Provider or its principals receive a designation from the federal government that they are debarred, suspended, proposed for debarment, or declared ineligible by a federal agency. The Purchaser may consider suspension or debarment to be may by cause for implementing high risk contract provisions under Article 23 "Special conditions for high risk contract" or for revising or terminating the contract under Article 21 "Revision or termination of the contract."

Article 10 Eligibility

The Provider shall provide services only to individuals who are eligible for services. The Provider and Purchaser agree that the eligibility of individuals to receive the services to be purchased under this Agreement from the Provider will be determined by the Purchaser.

An individual is entitled to the right of a fair hearing concerning eligibility and the Purchaser shall inform individuals of this right. The Provider shall provide clients with information concerning their eligibility rights and how to appeal those rights.

Article 11 Health Insurance Portability and Accountability Act of 1996 "HIPAA" Applicability

Section 9.1 General Applicability

The Provider agrees to comply with the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the extent those regulations apply to the services the Provider provides or purchases with funds provided under this contract.

Section 9.2 Business Associate Agreement

In addition, certain functions included in this agreement may be covered within HIPAA rules. As such the Purchaser must comply with all provisions of the law and has determined that Provider is a "Business Associate" within the context of the law. As a result, the Purchaser requires Provider to sign and return with this contract the Business Associate Agreement, which will be included and made part of this agreement.

Article 12 Indemnity and Insurance

Section 12.1 Indemnity

The Provider agrees that it will at all times during the existence of this Contract indemnify the Purchaser against any and all loss, damages, and costs or expenses which the Purchaser may sustain, incur or be required to pay by reason of any eligible client's suffering, personal injury, death or property loss resulting from participating in or receiving the care and services to be furnished by the Provider under this Agreement. However, the provisions of this paragraph shall not apply to liabilities, losses, charges, costs, or expenses caused by the Purchaser.

Section 12.2 Insurance

Provider agrees that, in order to protect itself as well as Purchaser under the indemnity provision set forth in the above paragraph, Provider will at all times during the terms of this Contract keep in force a liability insurance policy issued by a company authorized to do business in the State of Wisconsin and licensed by the State of Wisconsin and licensed by the Office of the Commissioner of Insurance. Upon signing this Contract, Provider will furnish Purchaser with a "Certificate of Insurance" verifying the existence of such insurance. In the event of any action, suit, or proceedings against Purchaser upon any matter indemnified against, Purchaser shall notify the purchaser by certified mail within five working days.

Article 13 Independent Contractor

Nothing in this contact shall create a partnership or joint venture between the Purchaser and the Provider. The Provider is at all times acting as an independent contractor and is in no sense an employee, agent or volunteer of the Purchaser.

Article 14 Licenses, Certification, and Staffing

Section 14.1 License and Certification
The Provider shall meet state and federal services standards and applicable state licensure and certification requirements as expressed by state and federal rules and regulations applicable to the services covered by this contract. The Provider shall attach copies of its license or certification document and the most recent licensing or certification report concerning the provider to this contract when returning the signed contract to the Purchaser. During the contract period, the Provider shall also send the Purchaser copies of any licensing inspection reports within 5 days of receipt of such reports.

Section 14.2 Staffing
The Provider shall ensure that staff providing services are properly supervised and trained and that they meet all of the applicable licensing and certification requirements.

Article 16 Matching, Level of Effort and Earmarking

No Matching, level of effort or earmarking requirements.

Article 17 Payment and Allowable Cost

Section 17.1 Amount paid under contract
The maximum payment under this contract is **$12,000.00.** Actual total payment will be based upon the amount of service authorized by the Purchaser and the amount of service performed by Provider. It is understood and agreed by all parties that the Purchaser assumes no obligation to purchase from the Provider any minimum amount of services as defined in the terms of this contract.

Section 17.2 Basis for Payments
Payments for services covered by this contract shall be made on a unit-times-unit-price basis with limited profit or reserve and in accordance with the "order of payment" requirements for the funding program, less client fees and other collection made by the Provider for services covered by this contract. Final settlement of the contract will be based on audit.

SPC or HIPAA code for service	***Service***	*# of Clients* (a)	Client Services Unit** (b)	Rate/Unit* (excluding room & board) (c)	Room & board/ unit (d)	Total per service (e) axbx(c+d)
	Speech Therapy, Physical Therapy, Occupational Therapy		150 hrs	$20.00/15 min		$12,000.00
					Contract total (sum of column e)	**$12,000.00**

Section 17.2.1 Units and prices – The units and prices for each service purchased from the Provider are included in the table below:

The Purchaser shall determine the type of services provided and the number of units of services provided for each client. The Purchaser will not reimburse the Provider for any unit of service not previously authorized by the Purchaser.

(See Article 22 "Services to be Provided" for description of the services purchased under this contract.)

(See Article 21 "Revision or termination of the contract" for revision of units or prices.)

Section 17.2.2 Profit or reserves– The purchaser allows the Provider to have profit (for-profit providers only) or reserve (non-profit provides only). The profit and reserve are limited by expenditures on allowable cost that the Provider incurs in performing the services purchased under this contract. Allowable costs, profit, and reserve are defined in the Allowable Cost Policy Manual (online at http://www.dhfs.state.wi.su/grants/Administration/ACPM.HTM).

Section 17.4 Reporting for payment
Each month, the Provider shall report the units of service provided during the month. All information reported to the Purchaser shall be supported by the Provider's records. The report is due to the Purchaser on the 14th day following the end of the report month. If the Provider's report is complete and timely, the expected payment date is the 20th day following the end of the report month. (See Article 18 "Records" and Article 19 "Reporting."

Section 17.5 Payment in excess of earned amount
Provider shall return to Purchaser funds paid in excess of the amount earned under this contract within 90 days of the end of the contract period. If the Provider fails to return funds paid in excess of the amount earned, the Purchaser may recover the excess payment from subsequent payments made to the Provider or through other collection means. The allowable cost of standard programs shall be determined pursuant to the Department of Health and Social Services' *Allowable Costs Policy Manual*.

Article 18 Records

Section 18.1 Maintenance of records
Provider shall maintain such records and financial statements as required by state and Federal laws, rules, and regulations.

Section 18.2 Access to records
The Provider shall permit appropriate representatives for the Purchaser to have timely access to the Provider's records and financial statements as necessary to review the Provider's compliance with contract requirements for the use of the funding.

Article 19 Reporting

Provider shall comply with the reporting requirements of Purchaser. All reports shall be in writing and, when applicable, in the format specified by the Purchaser. All reports shall be supported by the Providers records (See XI "Records").

Article 20 Resolution of Disputes

The Provider may appeal decisions of the Purchaser in accordance with the terms and conditions of the contract and Chapter 68, Wis. Stats.

Article 21 Revision or Termination of this Contract

Section 21.1 Cause for revision or termination of this contract

Failure to comply with any part of this contract may be considered cause for revision, suspension, or termination.

Section 21.2 Revision of this contract
Either party may initiate revision of this contract. Revision of this contract must be agreed to by both parties by an addendum signed by their authorized representative.

Section 21.3 Termination of this contract
Either party may terminate this contract by a 30-day written notice to the other party.

Upon termination, the Purchaser's liability shall be limited to the costs incurred by the Provider up to the date of termination. If the Purchaser terminates the contract for reasons other than non-performance by the Provider, the Purchaser may compensate the Provider for an amount determined by mutual agreement of both parties.

Article 22 Services to be Provided

Section 22.1 Description of services
For each eligible client referred by the Purchaser, the Provider agrees to provide the following services:

Speech Therapy
Occupational Therapy
Physical Therapy

Section 22.2 Developing Individual Service Plans/ISP
The Provider shall develop an Individual Service Plan for each client within 30 days following the date the Purchaser referred the client to the Provider. The Provider shall: (a) ensure that the Individual Service Plan complies with applicable standards; and (b) promptly submit the plan upon completion to the Purchaser for review and approval. The Provider agrees to work with the Purchaser as necessary when the Provider is developing an Individual Service Plan.

The Provider agrees to work with the Purchaser when the Purchaser is developing the Purchaser's Individual Service Plan.

Section 22.3 Implementing Individual Service Plans
The Provider shall provide the service specified in this Article and in the Provider's Individual Service Plan for each client, as authorized by the Purchaser. In providing services, the Provider shall:

a. Transfer a Client from one category of care or service to another only with the approval of the Purchaser (s. 46.036(4)(d) Wis. Stats.).

b. Coordinate with other service providers as necessary to achieve the client's goals as identified in the Purchaser's and Providers Individual Service Plans;

c. Obtain service from another party only with prior written approval form the Purchaser. If the Provider obtains services for any part of this Agreement from another party, the Provider is responsible for fulfillment of the terms of the contract.

Section 22.4 Inability to provide quality or quantity of services
The Provider shall notify the Purchaser in writing and delivered in person or by registered mail whenever it is unable to provide the required quality or quantity of services. Upon such notification, the Purchaser and Provider shall determine whether such inability will require a revision or termination of this contract. (See Article 21 "Revision or termination of the contract.")

Section 22.5 Documentation of quality and quantity of services
The Provider shall retain all documentation necessary to adequately demonstrate the time, duration, location, scope, quality, and effectiveness of services rendered under the contract. The Purchaser reserves the right to not pay for units of services reported by the Provider that are not supported by documentation required under this contract.

Section 22.6 Standards for performance in delivery of services
The Purchaser will monitor the Provider's performance and will use the results of this monitoring to evaluate the Provider's ability to provide adequate services to clients. If the Provider fails to meet contract goals and expected results, the Purchaser may reduce or terminate the contract

Section 22.7 Assessing performance in delivery of services
The Purchaser retains sole authority to determine whether the Provider's performance under the contract is adequate. The Provider agrees to the following:

a. The Provider shall allow the Purchaser's care manager and contracting staff to visit the Provider's facility or work site at any time for the purposes of ensuring that services are being provided as specified in the Plan of Care and the contract.

b. Upon request by the Purchaser or its designee, the Provider shall make available to the Purchaser all documentation necessary to adequately assess Provider performance.

c. The Provider will cooperate with the Purchaser in its efforts to implement the Purchaser's quality improvement and quality assurance program.

Signatures

A. This contract is agreed upon and approved by the authorized representative's of **Marinette County Health and Human Services** and **<<<Provider name>>>** as indicated below.

B. This contract becomes null and void if the time between the purchaser's authorized representative signature and the provider's authorized representative signature on this contract exceeds sixty days.

For Purchaser:

L. William Topel_____ _____
Director **Date**

Katherine K. Brandt_____ _____

County Clerk **Date**

For Provider:

<<<name>>> _____ _____
Chief Financial Officer **Date**

BUSINESS ASSOCIATE AGREEMENT

As required under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

This Agreement ("Agreement") amends and is hereby incorporated into the existing agreement known as Purchase of Service Contract #04-015 "Agreement", entered into by and between <<<Provider name>>> herein after referred to as "(Provider)" and Marinette County Health & Human Services Department herein after referred to as "(Purchaser)" on January 1, 2004.

This Agreement is specific to those Services and Programs included in the Agreement where it has been concluded that the (Provider) is performing specific functions on behalf of (Purchaser) that have been determined to be covered by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

[(Provider) functions or activities within this agreement may include, but are not limited to the following: (i) claims processing or administration,, (ii) data analysis, processing or administration, (iii) utilization review, (iv) quality assurance, (v) billing, (vi) benefit management, (vii) practice management, or (viii) repricing]

The (Purchaser) and (Provider) mutually agree to modify the Agreement to incorporate the terms of this Agreement to comply with the requirements of HIPAA's implementing regulations, Title 45, Parts 160 and 164 of the Code of Federal Regulations ("Privacy Rule"), dealing with the confidentiality of health or health-related information, and Title 45, Part 142 of the Code of Federal Regulations ("Security Rule"), dealing with the standards for the security of individual health information that is electronically maintained or transmitted, and Title 45, Part 162 of the Code of Federal Regulations ("Transaction Rule") dealing with standards for electronic transactions. If any conflict exists between the terms of the original Agreement and this Agreement, the terms of this Agreement shall govern.

1. Definitions:
    a. Protected Health Information (PHI) means any information, whether oral or recorded in any form or medium, that: (i) relates to the past, present or future physical or mental condition of any Individual; the provision of health care to an Individual; or the past, present or future payment of the provision of health care to an Individual; and (ii) identifies the Individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual. PHI includes demographic information unless such information is de-identified according to the Privacy Rule.
    b. Individual means the person who is the subject of PHI, and shall include a person who qualifies under the Privacy Rule as a personal representative of the Individual.
    c. Capitalized terms used in this Agreement, but not otherwise defined shall have the same meaning as those terms in the HIPAA Rules.

2. Prohibition on Unauthorized Use or Disclosure of PHI: (Provider) shall not use or disclose any PHI it creates or receives on behalf of the (Purchaser) except as permitted or required by the Agreement or this Agreement, as permitted or required by law, or as otherwise authorized in writing by the (Purchaser).

3. Use and Disclosure of Protected Health Information: (Provider) may use or disclose PHI only for the following purpose(s):

a. for the proper management and administration of named function or activity and provision of healthcare services within the named function or activity or,
b. for meeting its obligations as set forth in any agreements between the parties evidencing their business relationship, or
c. as would be permitted by the HIPAA Privacy Rule if such use or disclosure were made by The (Purchaser) or as required by applicable law, rule or regulation, or,
d. for Data Aggregation purposes for the Health Care Operations of the (Purchaser). [45 CFR §164.504(e)(2)(i), 164.504(e)(2)(ii)(A) and 164.504(e)(4)(i)] or,
e. for use in (Provider) operations as outlined in paragraph 4 below.

4. Use of PHI for Use in (Provider's) Operations: (Provider) may use and/or disclose PHI it creates or receives on behalf of the (Purchaser) to the extent necessary for (Provider's) proper management and administration, or to carry out (Provider's) legal responsibilities, only if:

    a. The disclosure is permitted or required by law; or
    b. (Provider) obtains reasonable assurances, evidenced by written contract, from any person or organization to which (Provider) shall disclose such PHI that such person or organization shall:

        (i) hold such PHI in confidence and use or further disclose it only for the purpose for which (Provider) disclosed it to the person or organization, or as required by law: and
        (ii) notify (Provider) who shall in turn promptly notify the (Purchaser), of any instance which the person or organization becomes aware of in which the confidentiality of such PHI was breached.

5. Safeguarding and Maintenance of PHI: For all PHI it creates or receives from or receives on behalf of the (Purchaser), (Provider) shall develop, implement, maintain, and use:

    a. appropriate administrative, technical, and physical safeguards to prevent the improper use or disclosure of all PHI, in any form or media: and,
    b. appropriate administrative, technical, and physical security measures to preserve the confidentiality, integrity and availability of all electronically maintained or transmitted PHI.

    (Provider) shall document and keep these safeguards and security measures current and available for inspection, upon request. (Provider's) security measures must be consistent with HIPAA's Security regulations, Title 45, Part 142 of the Code of Federal Regulations ("Security Rule"), once these regulations are effective.

6. Subcontractors and Agents: (Provider) agrees to ensure that any agents, including subcontractors, to whom it provides PHI received from, or created or received by the (Provider) on behalf of the (Purchaser), agree to the same restrictions and conditions that apply to the (Provider) with respect to such information. This provision does not apply to the use or disclosure of PHI for Treatment by subcontractors who are providers of Health care within the named function or activity.

7. Compliance with Electronic Transactions and Code Set Standards: If (Provider) conducts any Standard Transaction as defined in 45 CFR §164.504 on behalf of the (Purchaser) within the named programs, (Provider) shall comply, and shall require any subcontractor or agent conducting such Standard Transaction to comply, with each applicable requirement of Title 45, Part 162 of the Code of Federal Regulations. (Provider) shall not enter into, or

permit its subcontractors or agents to enter into, any agreement in connection with the conduct of Standard Transactions for or on behalf of the (Purchaser) that:

a. changes the definition, data condition, or use of a data element or segment in a standard Implementation Specification; or
b. adds any data elements or segments to the Maximum Defined Data Set; or
c. uses any code or data elements that are either marked "not used" in the standard's Implementation Specification(s) or are not in the standard's Implementation Specifications(s); or
d. changes the meaning or intent of the standard's Implementations Specification(s).

(Provider) agrees to comply with all provisions of the HIPAA Standards for Electronic Transactions rules regarding additional requirements for health plans [if it is determined that the (Purchaser) is a Health Plan] as set forth in CFR §162.925 as follows:

a. General rules.

   (i) if an entity requests the (Provider) to conduct a Transaction as a standard Transaction, the (Provider) must do so.
   (ii) the (Provider) may not delay or reject a Transaction, or attempt to adversely affect the other entity or the Transaction, because the Transaction is a standard Transaction.
   (iii) the (Provider) may not reject a standard Transaction on the basis that it contains data elements not needed or used by the (Provider) (for example, coordination of benefits information).
   (iv) the (Provider) may not offer an incentive for a health care provider to conduct a Transaction covered by this part as a Transaction described under the exception provided for in CFR 45 §162.923(b).
   (v) the (Provider) that operates as a health care clearinghouse, or requires an entity to use a health care clearinghouse to receive, process, or transmit a standard Transaction may not charge fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction to, or from, the (Provider).

b. Coordination of benefits. If the (Provider) receives a standard Transaction and coordinates benefits with another Health Plan (or another payer), it must store the coordination of benefits data it needs to forward the standard Transaction to the other Health Plan (or other payer).

c. Code sets. The (Provider) must meet each of the following requirements:

   (i) Accept and promptly process any standard Transaction that contains codes that are valid, as provided in subpart within this part.
   (ii) Keep code sets for the current billing period and appeals periods still open to processing under the terms of the health plan's coverage.

(The following paragraph may be replaced by one that states "(Provider) must be compliant with electronic Transactions and code set standards no later than October 16, 2002" if the (Purchaser) or (Provider) did not file an extension.)

As set forth in CFR 45 §162.900(b)(1)(2) and the Administrative Simplification Compliance Act (ASCA) and consistent with the (Purchaser's) extension filing, the (Provider) must be compliant with electronic Transactions and code set standards no later than October 16, 2003.

8. Access to PHI: At the direction of the (Purchaser), (Provider) agrees to provide access to any PHII held by (Provider) which the (Purchaser) has determined to be part of the (Purchaser's) Designated Record Set, in the time and manner designated by the (Purchaser). This access will be provided to the (Purchaser) or, as directed by the (Purchaser), to an Individual, in order to meet the requirements under the Privacy Rule.

9. Amendment or Correction to PHI: At the direction of the (Purchaser), (Provider) agrees to amend or correct PHI held by (Provider) and which the (Purchaser) has determined to be part of the (Purchaser's) Designated Record Set, in the time and manner designated by the (Purchaser).

10. Reporting of Unauthorized Disclosures or Misuse of PHI: (Provider) shall report to the (Purchaser) any use or disclosure of PHI not authorized by this Agreement or in writing by the (Purchaser). (Provider) shall make the report to the (Purchaser's) Privacy Official not less than one (1) business day after (Provider) learns of such use or disclosure. (Provider's) report shall identify: (i) the nature of the unauthorized use or disclosure, (ii) the PHI used or disclosed, (iii) who made the unauthorized use or received the unauthorized disclosure, (iv) what (Provider) has done or shall do to mitigate any deleterious effect of the unauthorized use or disclosure, and (v) what corrective action (Provider) has taken or shall take to prevent future similar unauthorized use or disclosure. (Provider) shall provide such other information, including a written report, as reasonably requested by the (Purchaser's) Privacy Official, or his or her designee.

11. Mitigating Effect of Unauthorized Disclosures or Misuse of PHI. (Provider) agrees to mitigate, to the extent practicable, any harmful effect that is known to (Provider) of a misuse or unauthorized disclosure of PHI by (Provider) in violation of the requirements of this Agreement.

12. Tracking and Accounting of Disclosures: So that the (Purchaser) may meet its accounting obligations under the Privacy Rule, (Provider) agrees to the following:

    a. Disclosure Tracking. Starting April 14, 2003, for each disclosure not excepted under subsection (b) below, (Provider) will record for each disclosure of PHI it makes to the (Purchaser) or a third party of PHI that (Provider) creates or receives for or from the (Purchaser) (i) the disclosure date, (ii) the name and (if known) address of the person or entity to whom (Provider) made the disclosure, (iii) a brief description of the PHI disclosed, and (iv) a brief statement of the purpose of the disclosure. For repetitive disclosures which (Provider) makes to the same person or entity, including the (Purchaser), for a single purpose, (Provider) may provide (i) the disclosure information for the first of these repetitive disclosures, (ii) the frequency, periodicity or number of these repetitive disclosures, and (iii) the date of the last of these repetitive disclosures. (Provider) will make this log of disclosure information available to the (Purchaser) within five (5) business days of the (Purchaser's) request.

    b. Exceptions from Disclosure Tracking. (Provider) need not record disclosure information or otherwise account for disclosures of PHI that meet each of the following conditions:

        (i) the disclosures are permitted under this Agreement, or are expressly authorized by the (Purchaser) in another writing; and,
        (ii) the disclosure is for one of the following purposes:

1. the (Purchaser's) Treatment, Payment, or Health Care Operations;
2. in response to a request from the Individual who is the subject of the disclosed PHI, or to that Individual's Personal Representative;
3. made to persons involved in that individual's health care or payment for health care;
4. for notification for disaster relief purposes;
5. for national security or intelligence purposes; or,
6. to law enforcement officials or correctional institutions regarding inmates.

c. Disclosure Tracking Time Periods. (Provider) must have available for the (Purchaser) the disclosure information required by this section for the six-year period preceding the (Purchaser's) request for the disclosure information (except (Provider) need have no disclosure information for disclosures occurring before April 14, 2003).

13. Accounting to the (Purchaser) and to Government Agencies. (Provider) shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or on behalf of, or created for, the (Purchaser) available to the (Purchaser), or at the request of the (Purchaser), to the Secretary of the federal (Purchaser) of Health and Human Services (HHS) or his/her designee, in a time and manner designated by the (Purchaser) or the Secretary or his/her designee, for the purpose of determining the (Purchaser's) compliance with the Privacy Rule. (Provider) shall promptly notify the (Purchaser) of communications with HHS regarding PHI provided by or created by the (Purchaser) and shall provide the (Purchaser) with copies of any information (Provider) has made available to HHS under this provision.

14. Term and Termination:

a. This Agreement shall take effect upon execution.
b. In addition to the rights of the parties established by the underlying Agreement, if the (Purchaser) reasonably determines in good faith that (Provider) has materially breached any of its obligations under this Agreement, the (Purchaser), in its sole discretion, shall have the right to:
   (i) exercise any of its rights to reports, access and inspection under this Agreement; and/or
   (ii) require (Provider) to submit to a plan of monitoring and reporting, as the (Purchaser) may determine necessary to maintain compliance with this Agreement; and/or
   (iii) provide (Provider) with a defined period to cure the breach; or
   (iv) terminate the Agreement in accordance with statutes

c. Before exercising any of these options, the (Purchaser) shall provide written notice of preliminary determination to (Provider) describing the violation and the action it intends to take.

15. Return or Destruction of PHI: Upon termination, cancellation, expiration or other conclusion of the Agreement, (Provider) shall:

a. Return to the (Purchaser) or, if return is not feasible, destroy all PHI and in whatever form or medium that (Provider) received or created on behalf of the (Purchaser). This provision shall also apply to all PHI that is in the possession of

subcontractors or agents of (Provider). In such case, (Provider) shall retain no copies of such information, including any compilations derived from and allowing identification of PHI. (Provider) shall complete such return or destruction as promptly as possible, but not less than thirty (30) days after the effective date of the conclusion of this Agreement. Within such thirty- (30) day period, (Provider) shall certify on oath in writing to the (Purchaser) that such return or destruction has been completed.

b. If (Provider) believes that the return or destruction of PHI is not feasible, (Provider) shall provide written notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction is not feasible, (Provider) shall extend the protections of this Agreement to PHI it receives or creates on behalf of the (Purchaser), and limit further uses and disclosures of such PHI to those purposes that make the return or destruction of the information infeasible, for so long as (Provider) maintains the PHI.

16. Miscellaneous:

a. Automatic Amendment: Upon the effective date of any amendment to the HIPAA rules, this Agreement shall automatically amend so that the obligations imposed on (Provider) remain in compliance with such regulations.
b. Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits the (Purchaser) to comply with the HIPAA Rules.
c. *[This paragraph is optional] (*Provider) shall submit to the (Purchaser) plans for compliance with the HIPAA rules along with periodic reports of progress of the plan implementation. The plans and progress reports shall be in the manner, form and timeframe determined by the (Purchaser).

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf.

Marinette County Health & Human Services	<<<Provider name>>>
By: _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____

Contract 04-015
<<<Provider name>>>

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Supportive Living
DSL-2558 (Rev. 11/2002)

STATE OF WISCONSIN
Completion of this form meets the requirements of the State/County contract specified under the Wisconsin Statutes. S. 46.03 (12), 46.275, 46.278 (2)

COUNTY CRITICAL INCIDENT REPORT

Instructions: This form must be completed in its entirety. Additional information may be attached to supplement information provided on the report form. FAX this form to the Bureau of Developmental Disabilities Services (BDDS) Critical Incident Contact in Central Office assigned to this individual within 30 days of the incident. Additional material that is not available due to reasons beyond the county's control may be sent under cover letter at a later date. Personally identifiable information on this form is collected for the purpose of improving quality of services and will only be used for that purpose.

1. Date Form Completed mm/dd/yyyy)
2. Name - Primary Community Integration Specialist
3. Report Type (Check all appropriate)
☐ Original ☐ Update ☐ Correction ☐ Review Closed
4. Date Critical Incident Review Closed mm/dd/yyyy)

PERSON COMPLETING FORM INFORMATION

5. Name - Last
Name - First
Title
6. Name - Agency
7. Telephone Number

CASE MANAGER INFORMATION (If different from above)

8. Name - Last
Name - First
9. Telephone Number
10. Case Manager ID Number

PARTICIPANT INFORMATION

11. Name - Last
Name - First
MI
12. Birthdate (mm/dd/yyyy)
13. Gender
☐ Male ☐ Female
14. Medicaid Number
15. Telephone Number - Residential
16. Program
☐ BIW ☐ CIP 1A ☐ CIP 1B ☐ CSLA ☐ Other

EVENT

17. Date of Event (mm/dd/yyyy)
18. Location Event Occurred (Street, City, State, Zip Code)
19. Type of Setting

Residence
- ☐ Participant's private home or apartment
- ☐ Adult family home (1-2 beds)
- ☐ Adult family home (3-4 beds)
- ☐ CBRF
- ☐ Children's foster home

Other
- ☐ Work / day program
- ☐ Community work site
- ☐ Community setting; e.g., park, store, etc.
- ☐ Transport
- ☐ Another person's residence
- ☐ Other - Specify: _____

20. Allegation of caregiver misconduct?
☐ Yes ☐ No
21. Name - Provider Agency
22. Address - Provider Agency (Street, City, State, Zip Code)

INITIAL REPORT

23. Provide a brief description of initial event or allegation. Send additional documentation only if necessary.

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Supportive Living 2
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24. How did the reporter learn of this event?

If hospitalization or medical treatment was needed, complete the following.

25. Date of Treatment (mm/dd/yyyy)	26. Name - Institution Where Treatment Was Obtained

27. Reason for admission / treatment

28. Outcome of treatment

If the participant died, complete the following:

29. Date of Death (mm/dd/yyyy)	30. Official cause of death as reported on the death certificate

31. Check applicable event type(s) / allegations below. Check "Alleged Only" if there is doubt that the event occurred.

Event Type / Allegation	Alleged Only
Abuse	
☐ Mental / emotional	☐
☐ Physical	☐
☐ Sexual	☐
☐ Verbal	☐
Death	
☐ Accidental	☐
☐ Anticipated	☐
☐ Related to psychotropic medication*	☐
☐ Related to restraint*	☐
☐ Related to suicide*	☐
☐ Unanticipated medical	☐
Note: *Deaths related to above factors in certain facilities must be reported to the Department / DSL Death Review Committee within 24 hours.	
Hospitalization	
☐ Emergency medical	☐
☐ Mental health / behavior	☐
Law Authority Contact	
☐ Commission of crime	☐
☐ Victim of crime	☐
Misappropriation	
☐ Person's funds	☐
☐ Person's property	☐

Event Type / Allegation	Alleged Only
Neglect	
☐ Environmental	☐
☐ Fail to follow plan / poor care	☐
☐ Medical / failure to seek	☐
☐ Nutrition	☐
☐ Self-neglect	☐
☐ Unanticipated absence of provider	☐
Residence Damage	
☐ Fire	☐
☐ Other	☐
☐ Weather	☐
Other	
☐ Serious illness / injury / accident	☐
☐ Significant behavior that placed others at risk	☐
☐ Suicide attempt	☐
☐ Other rights violations	☐
☐ Unanticipated absence of participant	☐

32. Contact checklist. Check all persons / agencies contact by county, provider and person / guardian. Fill in the first date contacted in regard to this event. *Contacts may be required depending upon circumstances.

☐	**A.**	**Adult Protective Services**	
		Name - Agency	Date - First Contact (mm/dd/yyyy)
		Name - Contact Person	Telephone Number - Agency
☐	**B.**	**BDDS / Community Integration Specialist (CIS)** (Required)	
		Name	Date - First Contact (mm/dd/yyyy)
☐	**C.**	**Caregivers Investigation*** (608) 261-7651	Date - First Contact (mm/dd/yyyy)
☐	**D.**	**Child Abuse**	
		Name - Agency	Date - First Contact (mm/dd/yyyy)
☐	**E.**	**County Case Manager**	
		Name -Contact Person	Date - First Contact (mm/dd/yyyy)
☐	**F.**	**Elder Abuse**	
		Name - Agency	Date - First Contact (mm/dd/yyyy)
☐	**G.**	**Guardian** (Required)	
		Name	Date - First Contact (mm/dd/yyyy)
☐	**H.**	**Law Enforcement Agency**	
		Name - Agency	Date - First Contact (mm/dd/yyyy)
☐	**I.**	**Licensing ***	
		☐ **Adult** Name - Agency	Date - First Contact (mm/dd/yyyy)
		☐ **Children's** Name - Agency	Date - First Contact (mm/dd/yyyy)
☐	**J.**	**Other Providers** If additional space is needed, attach separate sheet.	
		Name - Agency	Date - First Contact (mm/dd/yyyy)
		Name - Agency	Date - First Contact (mm/dd/yyyy)
☐	**K.**	**Physician**	Date - First Contact (mm/dd/yyyy)
☐	**L.**	**Area Administration**	
		Name	Date - First Contact (mm/dd/yyyy)
☐	**M.**	**Residential Support Provider**	Date - First Contact (mm/dd/yyyy)
☐	**N.**	**Residential Support Provider**	Date - First Contact (mm/dd/yyyy)
☐	**O.**	**Wisconsin Coalition for Advocacy** Telephone Number. - Madison (608) 267-0214 Telephone Number - Milwaukee (414) 342-8700	Date - First Contact (mm/dd/yyyy)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
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33. Response Summary. Check all that apply; send updates as needed.

☐ **Nothing changed**

Case Management
☐ Additional services added to plan
☐ Higher level monitoring
☐ Terminated waiver participation
☐ Changed - New case manager is: _____

Day / Work Provider
☐ Same agency - staff changed
☐ Same agency - staff training provided
☐ Same agency - staff added
☐ Changed - New provider is: _____

Guardian
☐ Changed - New guardian is: _____
Telephone number: _____

Residential Provider
☐ Same agency - staff changed
☐ Same agency - staff training provided
☐ Same agency - staff added
☐ Changed - New provider is: _____

☐ **HFS 94 grievance filed**

☐ **Other** - Specify: _____

34. Narrative CI outcome.

35. In the internal reviews of this event, were there any recommendations offered to improve the quality of care for other waiver participants or changes in policy / procedure? If so, summarize what the recommendations / changes are and the plans for implementing them.

FOR BDDS USE ONLY

36. Name - Participant	37. Medicaid Number

38. Name - Staff Member Who Completed This Form	39. Event Date	40. Review Date

41. Check applicable event type(s) / allegations below. Check "Alleged Only" if there is doubt that the event occurred.

Event Type / Allegation	Alleged Only
Abuse	
☐ Mental / emotional	☐
☐ Physical	☐
☐ Sexual	☐
☐ Verbal	☐
Death	
☐ Accidental	☐
☐ Anticipated	☐
☐ Related to psychotropic medication*	☐
☐ Related to restraint*	☐
☐ Related to suicide*	☐
☐ Unanticipated medical	☐
Note: *Deaths related to above factors must be reported to the Department / DSL Death Review Committee within 24 hours.	
Hospitalization	
☐ Emergency medical	☐
☐ Mental health / behavior	☐
Law Authority Contact	
☐ Commission of crime	☐
☐ Victim of crime	☐
Misappropriation	
☐ Person's funds	☐
☐ Person's property	☐

Event Type / Allegation	Alleged Only
Neglect	
☐ Environmental	☐
☐ Fail to follow plan / poor care	☐
☐ Medical / failure to seek	☐
☐ Nutrition	☐
☐ Self-neglect	☐
☐ Unanticipated absence of provider	☐
Residence Damage	
☐ Fire	☐
☐ Other	☐
☐ Weather	☐
Other	
☐ Serious illness / injury / accident	☐
☐ Significant behavior that placed others at risk	☐
☐ Suicide attempt	☐
☐ Other rights violations	☐
☐ Unanticipated absence of participant	☐

42. BDDS Response Summary. Check all that apply and the date completed.

	Date Completed		Date Completed
☐ None			
☐ Informal follow-up	_____	☐ Caregiver referral	_____
☐ Behavior consult	_____	☐ Formal POC issued	_____
☐ Provide training	_____	☐ Formal POC issued	_____
☐ Additional field visit	_____	☐ ISP revision	_____
☐ Licensing referral	_____	☐ CI review closed	_____

43. Provide any additional information about the event you need to add to the record.

44. Review Planning

	Date Due
☐ Plan of correction	_____
☐ Targeted review	_____

45. ☐ Yes ☐ No Are there attachments in the paper file?

Instructions for Completing Critical Incident Reports

I. Overview

The Department of Health and Family Services is required by the Centers of Medicare and Medicaid (CMS) to insure the health, safety and welfare of Home and Community based waiver participants. The Department shares this responsibility with County agencies in the State-County Contract by requiring County compliance with the Medicaid Waivers Manual. Chapter IX of this Manual requires each County agency administering any of the waivers to have an adequate system to ensure waiver participants are adequately protected form physical, verbal and sexual abuse. Maltreatment, neglect, financial exploitation and violations of their rights under law. Chapter 9 also requires counties to have an effective response system when Incidents of this kind arise. The Manual also specifies Critical Incident Reporting requirements for counties. The Manual requires County agency staff to report Critical Incidents as defined here. Please refer to the Medicaid Waiver Manual, Chapter IX: Assuring Health, Safety and Welfare, for detailed information.

II. Timelines

The County must report all Critical Incidents to the assigned CIS within 30 days of the Incident. **If a CI has the potential of becoming a high profile situation, the County is asked to immediately contact the assigned CIS or the Bureau of Developmental Disabilities at (608) 266-0805 to alert them and seek any assistance that may be needed.**

Completion of the BDDS Critical Incident Report does not meet any other requirements for reporting events, deaths or misconduct to other state or County agencies. Please visit the Department web site for additional information regarding reporting requirements at www.dhfs.state.wi.us.

III. Procedures:

The following is a recommended sequence of procedures county staff and the service providers involved may wish to follow in responding to reportable critical incidents.

1. *Immediately upon learning of an allegation of a critical incident, the service provider should determine if the allegation is credible. If there is reasonable cause to believe that the report may be accurate, the service provider should proceed with the next steps listed here.*

2. The service provider's first responsibility is to take necessary actions to protect waiver participants from the potential of harm. In doing this, they should preserve possible evidence for an investigation if one is to be conducted.

3. The provider must notify the case manager/service/support coordinator or designated county staff of the allegation and results of any action taken. Agencies are expected to notify local law enforcement authorities in any situation where there is a potential violation of criminal law.

4. *The county case manager/ Service/support coordinator should notify the guardian is about the situation/ incident.*

5. **If an incident has the potential of becoming a high profile situation, county agency staff are asked to immediately contact their assigned CIS or the Bureau of Developmental Disabilities at (608) 266-0805 to alert them and seek any assistance that may be needed.** Knowledge of such situations by department staff often helps alleviate concerns that may come from legislators or the media about the adequacy of responses that might arise if the department is not so informed.

6. The county staff or their agents/contractors who are involved should promptly determine if the critical incident occurred and if the person's with on-site responsibility have taken the necessary steps to ensure participant health, safety and welfare as required by the waiver. County staff should also determine if the service provider's procedures and responses were adequate. The county must take action to ensure that any remedial action needed is taken.

7. If county staff determine that the situation or event occurred, they should next determine if a longer term, a substantive response or change is warranted. County staff should take all actions necessary to make the changes needed including substitution of provider, termination of contracts, etc. These may occur after the initial CIR but shall be reported in updates to the initial CIR.

8. The CIR is intended to summarize the details of the incident, the county's review and participant outcomes. Each such incident should also be viewed as a test of the adequacy of the county's response system. County staff shall send the completed Critical incident form (DSL 2558) to their assigned CIS. Reports shall be within 30 days of the incident unless other arrangements have been made with the CIS. For active situations, Counties are encouraged to submit the report earlier.

9. If a county is unable to gain access to certain findings or records within the 30 day time frame due to concurrent investigations or other extenuating circumstances beyond their control, the county should send in all available information with a notation that the initial report is not complete. County staff should indicate when the rest of the report is anticipated if that is known or can be predicted.

10. County agencies are responsible for "closing" all critical incident reports. Closing here means submitting a report and any necessary updates so that all pertinent information about the event and the response are included in the report. Follow up visits or future targeted reviews are usually not expected to be part of the report unless they occur within a short time frame.

11. The DSL/BDDS staff will review all CIRs. This review is intended to determine:
- if participant's health, safety and welfare are now adequately protected;
- that the response to the situation and event was reasonable and appropriate;
- that the county's procedures and system for responding to such incidents were adequate;
- that the participant's service plan is adequate;
- that where relevant, steps to prevent similar incidents were taken;
- that all service providers or staff involved in the incident appear to be adequately trained or that additional training needed is to be provided pursuant to the report;

12. County staff should take special note that all other required reporting procedures such as Child abuse reporting and the timelines of other required reports remain in force and are not replaced or superseded by this process.

III. Definition of Critical Incidents and Key Terms

1. **Critical Incidents** are events or situations that pose an immediate and/or serious risk to the physical or mental health, safety, or well being of a waiver participant. A Critical Incident may also involve the misappropriation of a waiver participant's property or a violation of the person's rights. Waiver participants covered by this include people with a developmental disability or acquired brain injury who participate in one of the Medicaid Waivers administered by the Bureau of Developmental Disabilities Services (BDDS). Critical Incidents that are alleged to have occurred as well as the results of internal investigations are to be reported. If the reported Critical Incident is determined to be unfounded, the report should still be submitted.

2. **Abuse** means any of the following:
   a. An act, omission or course of conduct by another that is inflicted intentionally or recklessly and that does at least one of the following:
      (1) Results in bodily harm or great bodily harm to the individual.
      (2) Intimidates, humiliates, threatens, frightens or otherwise harasses the individual.
   b. The forcible administration of medication with the knowledge that no lawful authority exists.

   Examples of abuse include:
   - mental/emotional abuse - threats of harm, name calling, blaming, ignoring, threatening to withhold personal property or denying client rights or use of tonal inflection that intimidates, humiliates, threatens, frightens or otherwise harasses the individual
   - physical abuse - hitting, slapping, pinching, or grabbing a person that causes pain or injury
   - physical abuse - use of a mechanical or chemical restraint, isolation or seclusion without prior Departmental approval
   - physical abuse - restricting the use of a mobility device or intentionally failing to provide necessary assistance for activities of daily living
   - sexual abuse - inappropriate physical contact, exposure to unwanted sexually explicit material or verbal harassment of a sexual nature
3. **Community setting** means a public location that is not under an agency's control such as a park, roadway, shopping center, YMCA or other public accommodation.
4. **Death-accidental** means an unanticipated death that is the consequence of a specific negative and unintentional event such as a medical error, motor vehicle accident, airway obstruction by a foreign object or food or ingestion of a toxic substance. An accidental death is not abuse or neglect.
5. **Death-anticipated** means a death that was medically predicted to occur within six months if only routine and comfort interventions was provided. Anticipated deaths do not include the death of a person with a life-long disability that has been reasonably stable.

6. **Death-related to psychotropics** means death that was contributed to by the use or withholding of a psychotropic medication, or adverse reactions to a psychotropic medication.
7. **Death-related to restraints** means the person was either in restraints, seclusion, or isolation at the time of death or the death was directly related to the proper or improper use of restraints, seclusion, or isolation.
8. **Death-related to suicide** means the participant intentionally placed himself or herself in harm with a reasonable belief that it would result in their death.
9. **Death-unanticipated** means a death that was not predicted or anticipated within 6 months, or caused by an accident. An unanticipated death may be the result of abuse, neglect, an emergency medical condition, high-risk medical procedure, or sudden decline from of a pre-existing medical condition. Deaths due to ruptured bowel, cardiac arrest, pneumonia, sepsis, seizure, or stroke are examples of unanticipated deaths. If the death was related to abuse or neglect, this must be documented in the CIR.
10. **Hospitalization-emergency** means unscheduled medical treatment needed for the sudden and unexpected onset of a medical situation that, if immediate medical attention was not received, could result in death or serious injury to the person.

Examples of emergency hospitalization include:

- admission for heart attack, stroke, severe shortness of breath,
- assessment following a significant trauma event
- significant loss of blood
- burns or frostbite over a large portion of the body

11. **Hospitalization-mental health/behavioral** means an emergency or pre-scheduled overnight admission for assessment or management of an unstable mental condition or high-risk behaviors that require management by a physician.

    Examples of mental health/behavioral hospitalization include:

    - emergency detention for mental health symptoms or behaviors
    - deterioration of behavior that requires inpatient assessment
    - admission to an inpatient psychiatric unit for urgent medication adjustment

12. **Isolation** means any process by which a person is physically or socially set apart by staff from others but does not include separation for the purpose of controlling contagious disease.
13. **Law authority contact** means a participant is the subject of an investigation by law enforcement or the victim of an event that is reported to law enforcement.

    Examples of law authority contacts that are a critical incident include:

    - motor vehicle accidents or driver violations that pose a safety risk to a participant **and** the participant is a passenger in the vehicle at the time of the accident or violation **or** is struck by a moving vehicle
    - physical detention by law authorities of a participant for disruptive behaviors, possible or actual legal action or parole revocation
    - investigation of possible criminal activity where a participant is the victim or alleged perpetrator of a crime such as sexual abuse or assault

    Examples of law authority contacts that are not a critical incident include:

    - parking tickets, minor “fender-benders”, moving violations that did not pose a risk of harm to a participant

14. **Mechanical support** means an apparatus that is used to properly align a person’s body or to help a person maintain his/her balance, or to promote mobility. (Use of a gait belt to provide support during mobility activities is a mechanical support.)

15. **Medical restraint** means an apparatus or procedure that restricts the free movement of a person during a medical procedure or prior to or subsequent to such a procedure to prevent harm to the individual or aid in recovery or when used to protect an individual during the time a medical condition exists.
16. **Neglect means** an act, omission or course of conduct that, because of the failure to provide adequate food, shelter, clothing, medical care or dental care, creates a significant danger to the physical or mental health of an individual.
    Examples of neglect include:
    - environmental – failure to maintain a building, furniture and associated spaces in a clean, well ventilated, and safe condition
    - environmental – failure to provide adequate sensory and mental stimulation appropriate the participant's needs
    - failure to follow plan/poor care - failure to provide support services to an individual according to the care plan or policies and procedures or in such a limited manner that the person's safety or health is compromised
    - medical - failure to provide medication as ordered, prompt and adequate physical care, seek appropriate medical treatment or report change in a participant's condition in a timely manner
    - nutritional - failure to provide adequate and appropriate food, water or other dietary services to meet the needs of the person
17. **Physical restraint** means a manual hold by a support worker or use of an apparatus other than a medical restraint or mechanical support, that interferes with the free movement of a person's limbs or body which the person is unable to remove easily.
    Examples of physical restraint include:
    - a locked room
    - a device or garment that interferes with an individual's freedom of movement and that the individual is unable to remove easily.
    - restraint by a facility staff member of a resident by use of physical force
    - disabling or interfering with a participant's use of a mobility device
    - withholding assistance to a dependent person for the purpose of interfering with the person's free movement
18. **Provider** means any person or agency that is paid by waiver, County, private or public funds for providing a service to the person.
19. **Psychotropic medication** means an antipsychotic, antidepressant, lithium carbonate or a tranquilizer.
20. **Response summary** means actions taken by the person/guardian, County or providers in response to the event or allegation.
21. **Seclusion** means physical or social separation from others by provider not including separation to prevent the spread of a communicable disease or cool down periods in an unlocked room as long as the person's presence in the room is voluntary.
22. **Service provider,** in this context, means a person who is providing paid or unpaid service or support pursuant to the person's individualized service plan. Service providers may be the person in contact with the waiver participant or someone who supervises the people in direct contact with the participant.
23. **Suicide** means the act of taking one's own life voluntarily and intentionally.
24. **Unanticipated absence** means a participant's whereabouts is unknown and he or she is considered missing.